Provider Participation Requirements (PP)

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Managed Care Enrolled Members

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted Managed Care Organizations (MCOs) and their network of providers. All providers must check eligibility (Refer to Chapter 3) prior to rendering services to confirm which MCO the individual is enrolled. The MCO may require a referral or prior authorization for the member to receive services. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations.

Even if the individual is enrolled with an MCO, some of the services may continue to be covered by Medicaid Fee-for-Service. Providers must follow the Fee-for-Service rules in these instances where services are "carved out." The carved-out services vary by managed care program. For example, where one program (Medallion 3.0) carves out Early Intervention, the CCC Plus program has this service as the responsibility of the MCO. Refer to each program's website for detailed information and the latest updates.

There are several different managed care programs (Medallion 3.0, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE) for Medicaid individuals. DMAS has different MCOs participating in these programs. For providers to participate with one of the DMAS-contracted managed care organizations/programs, they must be credentialed by the MCO and contracted in the MCO's network. The credentialing process can take approximately three (3) months to complete. Go to the websites below to find which MCOs participate in each managed care program in your area:

Ø Medallion 3.0:

http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx

Ø Commonwealth Coordinated Care (CCC):
http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx

Ø Commonwealth Coordinated Care Plus (CCC Plus):
http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx

Ø Program of All-Inclusive Care for the Elderly (PACE):
http://www.dmas.virginia.gov/Content_atchs/ltc/WEB%20PAGE%20FOR%20PACE%20Sites%20in%20VA.pdf

At this time, individuals enrolled in the three HCBS waivers that specifically serve individuals with intellectual and developmental disabilities (DD) (the Building Independence (BI) Waiver, the Community Living (CL) Waiver, and the Family and Individual Supports (FIS) Waiver) will be enrolled in CCC Plus for their non-waiver services only; the individual's DD waiver services will continue to be covered through the Medicaid fee-for-service program.

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, MCO enrollment, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except

holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

Participating Provider

A participating provider is an agency, program, or person meeting the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed Participation Agreement with DMAS.

Provider Enrollment

Any provider of services must be enrolled as a participating provider with DMAS prior to billing for any services provided to Medicaid/FAMIS/FAMIS MOMS recipients. Providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment Services Unit of Xerox State Healthcare; an original signature of the provider is required. Provider enrollment forms may be found on the DMAS website at www.dmas.virginia.gov. Please note that any DMAS enrolled provider can provide services for Fee-for-Service Medicaid, FAMIS, FAMIS Plus and FAMIS MOMS enrollees.

Upon receipt of the above information, the ten-digit National Provider Identifier (NPI) number that was provided with the enrollment application is **assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.**

DMAS is informing the provider community that NPIs may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share your NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs This manual contains information about provider qualifications and specific details concerning the Virginia Medical Assistance Program. Providers must comply with all sections of this manual to maintain continuous participation in the Virginia Medical Assistance Program.

Requests for Enrollment

All providers who wish to participate with Virginia Medicaid are being directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening

questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov.

If you have any questions regarding the online or paper enrollment process, please contact the Provider Enrollment Services at toll free 1-888-829-5373 or local 1-804-270-5105.

Provider Screening Requirements

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as “limited”, “moderate” or “high”. Please refer to the table at the end of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized

or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process. **The application fee requirements are also outlined in Appendix section of this provider manual.**

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied.

An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State’s Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

Revalidation Requirements

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via our web portal.

Registration into the Virginia Medicaid Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated

by CMS to satisfy our provider screening requirements.

Ordering, Referring, and Prescribing (ORP) Providers

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

Please go to Chapter V of this provider manual to review the new billing procedures related to the implementation of these new screening requirements.

Participation Requirements

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their participation agreements. Providers approved for participation in the Medicaid Program must perform the following activities as well as any others specified by DMAS:

- Immediately notify Provider Enrollment Services Unit, in writing, whenever there is a change in the information that the provider previously submitted. For a change of address, notify PES prior to the change and include the effective date of the change;
- Ensure freedom of choice to members in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;
- Ensure the member's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin;
- Provide services, goods, and supplies to members in full compliance with the requirements

of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to members of the same quality and in the same mode of delivery as provided to the general public;
- Charge DMAS for the provision of services and supplies to members in amounts not to exceed the provider's usual and customary charges to the general public;
- Accept as payment in full the amount reimbursed by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency ...." The provider should not attempt to collect from the member or the member's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the member, a spouse, or a responsible relative. The provider may not charge DMAS or a member for broken or missed appointments;
- Accept assignment of Medicare benefits for eligible Medicaid members;
- Use Medicaid Program-designated billing forms for submission of charges;
- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided;
- In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved;
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid members; and
- Hold information regarding members confidential. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

Provider Responsibilities to Identify Excluded Individuals and Entities

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.

2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.

3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Ste 1300

Richmond, VA 23219

-or-

E-mailed to: providerexclusions@dmas.virginia.gov

Participation Requirements for Licensed Physicians

Only physicians currently licensed in the Commonwealth of Virginia (or in the state in which he or she practices) to practice as doctors of medicine (M.D.) or doctors of osteopathy (D.O.) may apply for participation in the Virginia Medicaid Program by signing the authorized Participation Agreement, DMAS-101. Acceptance for participation is based upon the needs of the Program, pursuant to Section 32.1-325 of the *Code of Virginia*. Physicians who, in any of the 50 states, have relinquished or have had revoked their license to practice medicine will have their applications considered on a case-by-case basis, taking into consideration the needs of the Program and its responsibilities to members. The agreement(s) must be in effect at the time services are rendered in order for claims to be considered for payment. Each physician will be assigned a Virginia Medicaid provider identification number. Medicaid can pay only for services performed by the participating treating physician or under his or her direct, personal supervision. Records must fully disclose a sufficient amount of information to indicate the extent and nature of the physician's overall supervision and participation in the care and treatment of the patient.

In a teaching setting, the Virginia Medicaid Program will cover the services of an attending physician (other than an intern or resident) to an individual patient, when the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his or her patient. In the case of major surgical procedures or other complex or dangerous procedures or situations, such personal direction must include supervision in person by the attending physician. Payment will be made for the services of an attending physician who involves interns and residents in the care of his or her patient only if his or her services to the patient are of the same nature, in terms of responsibilities to the patient that are assumed and fulfilled, as the service he or she renders to his or her other paying patients.

In both the teaching and the non-teaching setting, as evidence that a covered service was rendered under the attending physician's supervision, the medical record must contain his or her signed or countersigned notes which show that he or she personally reviewed the patient's medical history, gave a physical examination, confirmed or revised the diagnosis, and visited the patient.

Physician Assistants

DMAS does not directly enroll Physician Assistants in the Virginia Medicaid Program, but allows Physician Assistants to bill for Medicaid covered services within their scope of practice through their supervising Physician’s National Provider Identifier, as long as the Physician is enrolled in the Virginia Medicaid program.

Telemedicine Services

In order to be eligible to provide telemedicine services a provider must be licensed and enrolled in the state Medicaid program in which they practice medicine. The provider must also hold a Virginia Department of Health Professions license to provide telemedicine services.

Telemedicine service providers provide real-time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. The Medicaid recipient is located with a provider at the "originating" site, while the "remote" provider renders services via the audio/video connection. Telemedicine encounters must be conducted in a confidential manner and any information sharing consistent with applicable federal and state laws and regulations and DMAS policy. Health Information Portability and Accountability Act of 1996 (HIPPA) confidentiality requirements are applicable to telemedicine encounters.

Locum Tenens Arrangement

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) provides that physicians may bill for the services of a substitute physician. Therefore, the Virginia Medical Assistance Program will allow for billing by the absent physician in cases where an informal reciprocal agreement exists between the physicians. This reciprocal agreement is limited to a period of 14 days with at least one-day elapsing before the beginning of another 14-day period.

Certification and Recertification (PP)

The Virginia Medicaid Program is dependent upon the participation and cooperation of physicians who provide or order health care services. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with community standards of medical practice.

Physicians, General

Medicaid recognizes the physician as the key figure in determining utilization of health services. The physician decides upon admission to a hospital; orders tests, drugs, and treatments; and determines the length of stay. The Program calls for substantiation of certain physician decisions as an element of proper administration and fiscal control. Payment for certain covered services may be made to a provider of services only if there is a physician's certification concerning the necessity of the services furnished, and, in certain instances, only if there is a physician's recertification to the continued need for the covered services.

- The institutional provider of services is responsible for obtaining the required physician certification and recertification statements and for retaining them on file for verification, when needed, by the intermediary or by the State Agency.
- Each provider of services determines the method by which the required physician certification and recertification statements are obtained. Use of specific procedures or specific forms is not required, so long as the approach adopted by the provider permits verification that required physician certification and recertification statements are entered on or included in forms, notes, or other records a physician normally signs in caring for a patient; a separate form may be used for this purpose. Each certification and recertification statement must be separately signed and dated at the time it is signed by a physician, except as otherwise specified in this section.
- The requirements for recertification (and for certification for inpatient hospital services furnished) set forth in this section specify certain information that must be included in the physician's statement. This required information need not be repeated in a separate statement if, for example, it is contained in the physician's progress notes. The physician's statement may merely indicate that the required information is contained in the patient's medical record, if this is so.
- Providers of services are expected to obtain timely certifications and recertifications. However, delayed certifications and recertifications can be honored when, for example, the patient was unaware of his or her eligibility for the benefits when he or she was treated. Delayed certifications and recertifications must include or be accompanied by an explanation for the delay, including any medical or other evidence the physician or provider considers relevant for explaining the delay. A delayed certification and one or more delayed recertifications may appear in one signed statement.

Inpatient Hospital Services

Certification

Federal regulation 42 CFR 456.60 requires a physician certification that inpatient hospital services are necessary for each hospitalized member. A physician must certify the need for inpatient care at the time of admission. The certification must be in writing and signed or initialed by an individual clearly identified as a doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The certification must be dated at the time it is signed.

The certification may be either a separate form to be included with the patient's records or a stamp stating "Certified for Necessary Hospital Admission" which is to be made an **identifiable** part of the physician orders, history and physical, or other patient records. This certification must be signed and dated by the physician at the time of admission or, if an individual applies for assistance while in the hospital, before payment is to be made by

the State Agency.

Federal regulation 42 CFR 456.80 requires that a written plan of care be established at the time of admission or before payment for care can be authorized for each member. The plan must be an identifiable part of patient records and must include:

- Diagnosis, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the individual;
- Any orders for medication, treatment, restorative or rehabilitative services, activities, social services, and diet;
- Plans to continue care as appropriate; and
- Plans for discharge.

Recertification

A physician, physician assistant, or nurse practitioner, acting within the scope of practice as defined by State law and under the supervision of a physician, must recertify at least 60 days after certification for each member that inpatient hospital services are needed.

This required information need not be repeated in a separate statement if, for example, it is contained in the physician's progress notes. The physician's statement may merely indicate that the required information is contained in the patient medical record, if this is so.

Long-Term Care Facilities

(Effective Date: Revised October 1, 1990)

Physician Certification and Recertification

In each case for which payment for inpatient nursing facility services or inpatient mental hospital services is made under the State Plan:

- In a nursing facility, a physician must approve a recommendation that an individual be admitted. The nursing home preadmission screening shall serve as the physician's admission or initial recommendation if the date of the screening occurred within 30 days of the date of the admission to a nursing facility. Recertification is not required for nursing facility residents.
- In a facility for the mentally retarded, the physician or nurse practitioner or clinical nurse specialist who is not employed by the facility and who is working

in collaboration with a physician must recertify that patients continue to require the specific level of care at least once every 365 days.

- In mental hospitals, recertifications are required in intensive psychiatric units and in hospital areas (medical-surgical units) at least every 60 days. In nursing facility areas, units, or buildings on the grounds of State mental hospitals, the certification requirements are the same as for nursing facilities, based on the certification of the unit.

  Note: The initial certification for either level of care must be dated and signed within 30 days prior to or at the time of admission. The date of the next recertification is computed from the date the initial certification was actually signed.

- Certification is not considered a pro forma act but rather a medical decision based on the professional evaluation of the patient's needs. The certification must justify the reasons for nursing facility placement and be signed (name and title) and dated (month, day, and year) by the attending physician or nurse practitioner or clinical nurse specialist as qualified on the preceding page. (Rarely would a diagnosis alone be acceptable as justification for nursing facility care.)

- For purposes of determining compliance, a recertification shall be considered to

  have been completed on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required if the physician or other person making the certification provides a written statement showing good cause why the recertification did not meet the schedule. The statement of good cause must be filed in the patient's record and be made available to the Department of Medical Assistance Services staff when audits for compliance are made. In the absence of clarifying regulations, the agency has not defined "good cause." Therefore, any statement made by the physician purporting to show good cause will be accepted if made in writing by the physician, nurse practitioner, or clinical nurse specialist responsible for making such recertification and filed in the patient's record.

- The Department of Medical Assistance Services accepts recertifications written and signed by nurse practitioners or clinical nurse specialists. Private-pay patients who apply for Medical Assistance must have their certification signed by the physician or other qualified health professional at the time an application is made for Medicaid eligibility determination.
- Certification reflecting the need for nursing home placement and the physician's progress note of the observed medical condition may be contained in the same note. However, these are two separate requirements, and one cannot

be substituted for the other.

NOTE: All physician or other health care professionals' documentation, including certifications, must be signed with the initials, last name, and title. All documentation must be completely dated with the month, day, and year. Mailing in certifications, orders, or progress notes is prohibited.

Physician's Plan of Care and Orders

A physician must approve a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. All residents must be seen by a physician, and orders must be renewed at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter (effective April 1, 1992). The most current page of the physician's orders must be the first page of the physician's order section in the medical record. "Renew orders" is acceptable if all current orders are on the same page of the physician's order sheet.

The plan of care must include diagnoses, symptoms, complaints, and complications, and any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and plans for discharge. Orders must be specific for individual needs, and all orders must be complete (i.e., the medication orders must include the medication name, dosage, frequency, and route of administration; restraint orders must include the specific times in which the restraint may be applied, the type of restraint to be used, and the periods of time in which restraint will be removed for resident exercise).

A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required. The initial physician visit must be made by the physician personally. Subsequent required physician visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner under the physician's supervision.

In facilities for the mentally retarded, the physician must also review the use of psychotropic drugs on at least a quarterly basis for adverse side effects and record the review in the medical records of residents receiving a psychotropic drug. If psychotropic drugs are utilized, there must be a behavioral program for that resident.

Progress Notes

It is expected that the physician will visit the resident and write progress notes, which reflect the observed medical condition of the resident. Physician progress notes should record any significant change between visits or record or elaborate when the resident's

condition is unchanged. The record must indicate the progress at each visit, any change in the diagnosis or treatment, and the resident's response to treatment.

Progress notes must be written for every nursing facility visit to a member and at least every 90 days. If a physician chooses to delegate the alternate patient visits (as described above), the physician assistant or nurse practitioner must write the progress notes for visits in which he or she was involved. Significant changes or problems in the patient's condition must be immediately reported to the physician.

DMAS will accept documentation written by an alternate physician, such as the Medical Director.

Home Health Services

Home health services include periodic nursing care under the direction of a physician. Such services are provided by participating home health agencies and can be used effectively by the physician for post-hospital care and periodic nursing care.

To be eligible for home health services, the patient must be essentially homebound. While this does not mean bedridden, the patient must meet at least one of the following conditions to be considered homebound:

- The patient's physical condition is such that there exists a normal inability to leave home without the assistance of others or the use of special equipment;
- The patient has a mental or emotional problem which is manifested in part by refusal to leave his or her home environment or is of such a nature that it would not be considered safe for him or her to leave home unattended;
- The patient is ordered to restrict his or her activity by the physician due to a weakened condition following surgery or heart disease of such severity that stress and physical activity must be avoided; or
- The patient has an active communicable disease, and the physician restricts the patient to prevent exposing others to the disease.

In addition, under the following conditions, Medicaid will reimburse for home health services when a patient is not essentially homebound when:

- The combined cost of transportation and medical treatment exceeds the cost of a home health services visit;
- The patient cannot be depended upon to go to a physician or clinic for the required treatment; as a result, he or she would, in all probability, have to be admitted to a hospital or nursing facility because of complications arising from the lack of treatment;

- The visits are for a type of instruction to the patient which can better be accomplished in the home setting; or
- The duration of the treatment is such that rendering it outside of the home is not practical.

When home health services are provided because of one of the above reasons, an explanation must be included on the Home Health Certification and Plan of Treatment (HCFA 485, 486, and 487 forms.

CERTIFICATION

The required physician's statement should certify that:

- The home health services were required because the individual was confined to his or her home (as described above).
- The individual needed skilled nursing care or home health aide services on an intermittent basis, or he or she needed physical or occupational therapy or speech- language pathology services.
- A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician.
- These services were furnished while the individual was under the care of a physician. The physician may be the patient's private physician or a physician on the staff of the home health agency or a physician working on an arrangement with the institution which is the patient's residence or, if the agency is hospital-based, a physician on the hospital or agency staff.

Recertification

A recertification is required at intervals of at least once every two months, should be signed by the physician who reviews the plan of treatment, and should preferably be obtained at a time when the plan of treatment is reviewed. The recertification statement should indicate the continuing need for services and should estimate how long home health services will be needed.

Certification and Recertification for Member Who Receives Services Prior to Entitlement

If any individual receives services before his or her entitlement to Medicaid benefits, the timing of certification and recertification will be determined as if the date of entitlement was the date of admission. For example, if any individual is admitted to a hospital before entitlement, the date of entitlement will determine the timing of certification and recertification, not the date of admission.

Timing Requirements for Provider Signatures
[Effective Date: 7-13-2017]

All physician services provided shall be documented in the medical record at the time they are rendered, whether in-person or via telehealth. All patient medical records, whether paper-based or electronic, shall be signed with the first initial, and last name and title and dated (month, day, and year) no later than 14 calendar days from the date of service delivery. The 14-day signature requirement shall apply in all cases, except where a federal or state signature deadline requires a time frame different than 14 days.

Use of Rubber Stamps for Physician Documentation
[Effective Date: 1-23-92]

When a rubber stamp is used, the individual whose signature the stamp represents must provide DMAS with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. All rubber-stamped signatures are also required to be accompanied by the initials of the physician and the date (month, day, year) at the time the rubber stamp is used.

The signature waiver form must be received 30 days prior to the date of the anticipated use of the rubber stamp. All documentation must be completely dated with the month, day, and year. Mailing in certifications, orders, or progress notes is prohibited.

Requirements of the Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each provider enrolled in the Virginia Medical Assistance Program has the responsibility for making provisions for individuals with disabilities in the provider's programs or activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

Requirements of the Civil Rights Act of 1964

All providers of care and suppliers of services under the contract with DMAS must comply with the requirements of Title VI of the Civil Rights Act of 1964, which requires that services be provided to Medicaid clients without regard to race, color, or national origin.

Utilization of Insurance Benefits

Virginia Medical Assistance Programs are “last pay” programs. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, state, or local programs, other insurance, or third party liability. Health, hospital, Workers’ Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medical Assistance Program will pay the amount of any deductible or co-insurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers’ Compensation** - No Virginia Medical Assistance Program payments shall be made for a patient covered by Workers’ Compensation.
- **Other Health Insurance** - When a consumer has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Virginia Medical Assistance Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.
- **Liability Insurance for Accidental Injuries** - DMAS will seek repayment from any settlements or judgments in favor of Medicaid/FAMIS/FAMIS MOMS recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and DMAS is billed for this treatment, DMAS should be notified promptly so action can be initiated by DMAS to establish any lien that may exist under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing DMAS.
- If there is an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid/FAMIS/FAMIS MOMS is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 form to the attention of the

Third Party Liability Unit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

(To obtain a copy of this form, see the “Replenishment of Billing Materials” section in Chapter V of this manual.)

Physician Documentation (PP)

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid members. Medical records must clearly document the

medical necessity for covered services. This documentation must be written at the time the service is rendered and must be legible and clear in the description of the services rendered. All documentation must be signed (name and title) and dated (month, day, year) on the date of service delivery. Dates may not be typed onto medical records in advance of the signature.

The provider is to select from the *Physicians' Current Procedural Terminology, Fourth Edition* (CPT) the procedure code which most appropriately describes the service rendered and documented. Please pay particular attention to the definitions and descriptions regarding classifications of the evaluation and management (E/M) services for new and established patients as contained in the introduction to the CPT. These same definitions and descriptions will be used to evaluate the documentation during Program audits of medical records.

A pre-existing written protocol, defined as a narrative explanation of an office or examination procedure, with contemporaneous medical record documentation may be considered in addition to the medical record to satisfy the documentation requirements. The protocol is not acceptable as a replacement for appropriate medical record documentation.

Specific points to be recorded in the medical records to meet the documentation requirements should include the following as appropriate:

- The present complaint;
- A history of the present complaint, the past medical history applicable to the complaint, and the family history when applicable to the complaint;
- The positive and negative physical examination findings pertinent to the present complaint;
- The diagnostic tests ordered, if any, and the positive and negative results;
- The diagnosis(es);
- The treatment, if any, including referrals. Any drugs prescribed as part of the treatment must have quantities and the dosage entered in the medical record;
- The observed medical condition of the patient, the progress at each visit, any change in the diagnosis or treatment, and the response to the treatment. Progress notes must be written for every office, clinic, nursing facility, hospital, or psychotherapy visit billed to Medicaid;
- The length of time and type of therapy (i.e., individual or group) for psychotherapy.

- The provider in solo practice must have a method of identifying the member and the treating physician for each service. However, entries from covering physicians must be signed by the covering physicians.
- In group practices, providers must have a verifiable method of identifying the member and the treating physician for each service.
- The documentation for care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.

- Signature (name and title) and date (month, day, year) on the date of service delivery. Dates may not be typed onto medical records in advance of the signature.

Examples of Medical Record Documentation

Office Visit with Follow-Up Visit

John Doe

Jan. 20, 1989 BP 120/70 T 98.6

C/O itching over back and legs x 2 wks.

Macular excoriated eruptions over back and lower legs. None on chest or abdomen.

HEENT WNL. Chest clear, heart regular.

Dermatitis, non-specific

Zone A Forte BID & HS

Prednisone 5 mg. TID #12
Chlorofed q12h

rtn 2 wks

Bob Roe, M.D.

Feb. 3, 1989 BP 110/70 T 98.6

Itch has resolved. C/O headache

HEENT WNL, chest clear, heart regular, abd soft ext WNL.

Headache

Esgic tab #60 1-2 tab q4h prn

Bob Roe, M.D.

Pediatric Office Visit with Follow-Up Visit

Jimmy Doe

Jan. 20 1989

CC: coughing, worse at night. Pulling at ears T 99

TMs injected with fluid. Tonsils injected and red. Coarse rhonchi with squeaks.

HCT 27.4 Strep screen- pos.

Plt 381,000

WBC 6.6

Grans 30-46%

Lymphs 36-54%

Acute tonsillitis

BOM

Anemia

Slophyllin 80 1 tsp QID

Amoxicillin susp. 250 mg. TID

Return 10 days

Jane Roe, M.D.

Jan. 31, 1989 T 98.8

Still coughing. Not pulling at ears.

Tonsils less injected. TMs less injected. Coarse rhonchi.

Resolving tonsillitis

Resolving BOM

URI

Rondec syrup 1 tsp q 4h prn

Jane Roe, M.D.

Psychotherapy Visit

John Smith

10/2/89

Individual therapy one hour. Therapy focused on the anxiety Mr. Smith experiences when in public places such as a grocery store or shopping mall. Mr. Smith reported following through with recommendations made during last session in regards to increasing the amount of time spent in a store while practicing relaxation exercises. Plan is to continue relaxation training in office coupled with systematic desensitization along with increased exposure to feared situations outside the office.

Jack Brown, M.D.

Jane Jones

10/2/89

Individual therapy one hour. Ms. Jones continues to report depressed feelings surrounding the break up of her marriage. Therapy focused on identification of origins of these feelings in relation to other losses in her life. Encouraging alternative coping style and plan to use a more cognitively based approach to deal

with negative thought patterns.

Jack Brown, M.D.

- All laboratory tests billed to the Program must have documented results. Those laboratory tests listed as quantitative tests by the CPT must be documented by a numerical result. Qualitative tests are to be documented by positive or negative. Those laboratory services requiring descriptive results are to be fully-documented. Documentation examples are listed below:

Quantitative tests:

WBC - 7,000/mm3

Glucose - 85 mg/dl

Qualitative tests:

Monoscreen - positive

Pregnancy test - negative

Descriptive tests:

Urine microscopy - clear, yellow-brown, few wbc, rare renal epithelial cell

Urine culture - greater than 105/ml E. coli

Medical Assistance Program Information

Federal regulations governing program operations require the Virginia Medical Assistance Program to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive a provider manual and Virginia Medical Assistance Program memoranda because he or she has access to the publications as part of a group practice.

To suppress the receipt of this information, the Xerox Provider Enrollment Services Unit requires the provider to complete the Mail Suppression Form and return it to:

Virginia Medicaid -PES

PO Box 26803

Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Upon receipt of the completed form, Xerox-PES will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

Termination of Provider Participation

A participating provider may terminate participation in the Virginia Medical Assistance Program at any time; however, written notification must be provided to the DMAS Director and Xerox-Provider Enrollment Unit (PEU) 30 days prior to the effective date. The addresses are:

Director

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia Medicaid -PES

P.O. Box 26803

Richmond, VA 23261-6803

DMAS may terminate a provider from participating upon 30 days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

Appeals Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial.

Termination of a Provider Contract Upon Conviction of a Felony

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or

2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

    a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined

as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2) For services that have already been rendered, a provider appeal is:

a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by

the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

MEMBER APPEALS

Information for providers seeking to represent a member in the member's appeal of an adverse benefit determination is located in Chapter III.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:

    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;

    - Email to appeals@dmas.virginia.gov; or

    - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director’s decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director’s Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Client Appeals

For client appeals information, see Chapter III of the Provider Manual.

Provider Risk Category Table

Application	Rule Risk Category	App Fee Requirement Yes (Y) or No (N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y
Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N
Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate - Revalidating High - Newly Enrolling	Y
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate - Revalidating High - Newly Enrolling	Y
Home Health Agency - Private Owned	Moderate - Revalidating High - Newly Enrolling	Y
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate - Revalidating High - Newly Enrolling	Y
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N
Private Duty Nursing	Limited	N
Federally Qualified Health Center	Limited	Y
Health Department Clinic	Limited	N
Rural Health Clinic	Limited	Y
Developmental Disability Waiver	Limited	N
Alzheimer's Assisted Living Waiver	Limited	N
Treatment Foster Care Program	Limited	N
Qualified Medicare Beneficiary (QMB)	Limited	N
ICF-Mental Health	Limited	Y
ICF-MR Community Owned	Limited	Y
ICF-MR State Owned	Limited	Y
Intensive Care Facility	Limited	Y
Skilled Nursing Home	Limited	Y
SNF-Mental Health	Limited	Y
SNF-MR	Limited	Y
Psych Residential Inpatient Facility	Limited	Y
Consumer Directed Service Coordination	Limited	N
Personal Care	Limited	N
Respite Care	Limited	N
Personal Emergency Response System	Moderate - Revalidating High - Newly Enrolling	Y
Case Management DD Waiver	Limited	N
CMHP Transition Coordinator	Limited	N
Transition Coordinator	Limited	N
PACE	Limited	N
Family Caregiver Training	Limited	N
Mental Retardation Waiver	Limited	N
Mental Health Services	Moderate - Revalidating High - Newly Enrolling	Y - only for Mental Health Clinics
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N